Today's Date:	FOR OFFICE USE - PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Birth date:	Age:	Sex: ☐ M ☐ F	Home phone no.: ( )
Street address:		Social Security no.:	Cell phone no.: ( )

E-Mail Address	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Primary Language: Translator Required? ☐ Yes ☐ No	☐Hispanic/ Latino ☐Black or African American ☐White/Caucasian ☐ Asian ☐ Native American or Alaska Native ☐ Pacific Islander ☐ Other (specify):

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Carrier:	Policy Number:	Group Number:	Policy Holder Name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:			Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if any):	Policy Number:	Group Number:	Policy Holder Name:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Pharmacy: Pharmacy Telephone:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

I HEREBY AUTHORIZE, MEDICAL WALK-IN & WELLNESS TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PAYMENT AT THE TIME OF THE VISIT. I UNDERSTAND THAT THE FEES SET BY THIS OFFICE MAY EXCEED WHAT MY INSURANCE CARRIER CONSIDERS TO BE REASONABLE AND CUSTOMARY CHARGES FOR THIS AREA. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL REGARDLESS OF THE DECISION MADE BY MY INSURANCE CARRIER.

I have read the above information, understand it completely and agree to its terms.

Print Name *Patient/Guardian signature* *Date*

Medical Walk-In & Wellness
162 Main St, Metuchen
New Jersey, 08840
Tel:-(732)494-8100
Fax:-(732)494-8101

MEDICAL WALK-IN & WELLNESS
YOUR HEALTH IS IN GOOD HANDS

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I.):	◯M ◯F	**DOB:**
Marital status: ◯Single ◯Partnered ◯Married ◯Separated ◯Divorced ◯Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Past Medical History: Please check all you have had problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Ulcers	☐ Indigestion	☐ Colitis	☐ Skin disease
☐ Diabetes	☐ Bronchitis Cancer	☐ Nausea	☐ Hepatitis or Jaundice	☐ Blood disorders
☐ Cancer	☐ Pneumonia	☐ Kidney stones	☐ Thyroid disease	☐ Venereal disease
☐ Heart Disease	☐ Cough	☐ Change in bowel habits	☐ Headaches/Migraines	☐ Anxiety
☐ Chest pain/palpitations	☐ Tuberculosis (T.B.)	☐ Weight loss/gain	☐ Drug Abuse	☐ Anemia
☐ Shortness of breath	☐ Hay Fever	☐ Hemorrhoids	☐ Arthritis	☐ Alcohol Abuse
☐ Swollen ankles/Gout	☐ Stomach pains	☐ Gall bladder disease	☐ Low back pain	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ◯Yes ◯No

Please turn to next page

Immunizations and dates:	Tetanus	Date:	Pneumonia	Date:
	Hepatitis	Date:	Chickenpox	Date:
	Influenza	Date:	MMR Measles, Mumps, Rubella	Date:

List your prescribed drugs and over-the-counter drugs, such as vitamins, herbs and inhalers		
Name the Drug	Dosage	Frequency Taken

Allergies to medications, X-Ray dyes, latex, or other substances	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	◯ Sedentary (No exercise)			
	◯ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	◯ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	◯ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?		◯ Yes	◯ No
	If yes, are you on a physician prescribed medical diet?		◯ Yes	◯ No
	# of meals you eat in an average day?			
	Rank salt intake	◯ Hi	◯ Med	◯ Low
	Rank fat intake	◯ Hi	◯ Med	◯ Low
Caffeine	None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		◯ Yes	◯ No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?		◯ Yes	◯ No
	Have you considered stopping?		◯ Yes	◯ No
	Have you ever experienced blackouts?		◯ Yes	◯ No
	Are you prone to “binge” drinking?		◯ Yes	◯ No
	Do you drive after drinking?		◯ Yes	◯ No

Please turn to next page

Tobacco	Do you use tobacco?	◯ Yes ◯ No
	Cigarettes – pks./day · Chew - #/day · Pipe - #/day · Cigars - #/day	
	# of years · Or year quit	
Drugs	Do you currently use recreational or street drugs?	◯ Yes ◯ No
	Have you ever given yourself street drugs with a needle?	◯ Yes ◯ No
Sex	Are you sexually active?	◯ Yes ◯ No
	If yes, are you trying for a pregnancy?	◯ Yes ◯ No
	If not trying for a pregnancy list contraceptive or barrier method used:	
	Any discomfort with intercourse?	◯ Yes ◯ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	◯ Yes ◯ No
Personal Safety	Do you live alone?	◯ Yes ◯ No
	Do you have frequent falls?	◯ Yes ◯ No
	Do you have vision or hearing loss?	◯ Yes ◯ No
	Do you have an Advance Directive or Living Will?	◯ Yes ◯ No
	Would you like information on the preparation of these?	◯ Yes ◯ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	◯ Yes ◯ No

FAMILY HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY

		AGE	CANCER (TYPE)	HIGH BLOOD PRESSURE	HEART DISEASE	DIABETES	STROKES	DRUG/ALCOHOL ABUSE	GLAUCOMA	BLEEDING DISEASE	OTHER (EXPLAIN)
Father				☐	☐	☐	☐	☐	☐	☐	
Mother				☐	☐	☐	☐	☐	☐	☐	
Sibling	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
Grandmother Maternal				☐	☐	☐	☐	☐	☐	☐	
Grandfather Maternal				☐	☐	☐	☐	☐	☐	☐	
Grandmother Paternal				☐	☐	☐	☐	☐	☐	☐	
Grandfather Paternal				☐	☐	☐	☐	☐	☐	☐	
Children	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	
	◯ M ◯ F			☐	☐	☐	☐	☐	☐	☐	

Please turn to next page

MENTAL HEALTH

Question	Yes	No
Is stress a major problem for you?	◯ Yes	◯ No
Do you feel depressed?	◯ Yes	◯ No
Do you panic when stressed?	◯ Yes	◯ No
Do you have problems with eating or your appetite?	◯ Yes	◯ No
Do you cry frequently?	◯ Yes	◯ No
Have you ever attempted suicide?	◯ Yes	◯ No
Have you ever seriously thought about hurting yourself?	◯ Yes	◯ No
Do you have trouble sleeping?	◯ Yes	◯ No
Have you ever been to a counselor?	◯ Yes	◯ No

WOMEN ONLY

Date of last pap and rectal exam?	Date of last Mammogram?
Date of last breast exam?	Date of last Colonoscopy?

MEN OVER 40 ONLY

Date of last prostate and rectal exam
Last time your stool was checked for blood?
Date of last Colonoscopy?

Notice of Privacy Practices & Permission of Patient Contact

My Signature below indicates that I have received and reviewed Medical Walk-In & Wellness notice of privacy practices

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PERMISSION OF PATIENT CONTACT(Effective April 2003 under Federal law)

Please provide at least two numbers where our staff might contact you

Home Phone: _____________Work Phone: ______________ Cell Phone: ____________

In the event that we cannot contact you at either, may we leave a message on any of these numbers?

Home Phone: __ **Yes** __ **no** Work Phone: __ **Yes** __ **no** Cell Phone: __ **Yes** ___ **no**

Please provide the names of any persons that you would permit us to discuss your medical status

Note: due to privacy laws we are not permitted to discuss health information with anyone not listed below

Name: ___________________________________ **Relationship:** _________________

Name: ___________________________________ **Relationship:** _________________

Name: ___________________________________ **Relationship:** _________________

Patients Name: ____

Patient Signature: _________________________________ **Date:** ____________

Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal care information is protected for privacy. The Privacy Rule was also created for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health information and relevant information about treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you reviewed our privacy notice

Print Name: _________________________Signature: _________________Date: _______

Compliance Assurance Notification For our Patients

To our Valued Patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that our employees, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding HIPAA with particular emphasis on the “privacy rule”. We strive to achieve the highest standards of ethics and integrity in performing services for our patients

It is our policy to properly determine appropriate use of PHI in accordance with government rules, laws and regulations. If you have questions or concerns, please reach out to us and we will remedy the situation promptly